

# Utilization Review

Cardiac Rehabilitation Services:

*Underutilized*

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# What is Cardiac Rehab?

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- “Cardiac rehabilitation services are comprehensive, long-term programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counselling. These programs are designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or re-infarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients<sup>1</sup>”

# Why is Cardiac Rehab Important?

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- Pooled data from randomized clinical trials of CR demonstrate a mortality benefit of approximately 20-25% and a trend towards reduction in nonfatal MI over a median follow-up of 12 months<sup>1</sup>.

1. J Am Coll Cardiol 2007;50:1400–33. (2007 CR Performance Measures from the AACVPR/ACC/AHA)

# Who's Eligible?

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- Phase I – Inpatient Cardiac Rehab
- Phase II – Early Outpatient Cardiac Rehab
  - MI/ACS CABG
  - PCI
  - Stable angina
  - Valve repair/replacement
  - Heart or heart/lung transplant
- Phase III – Long-term outpatient Cardiac Rehab

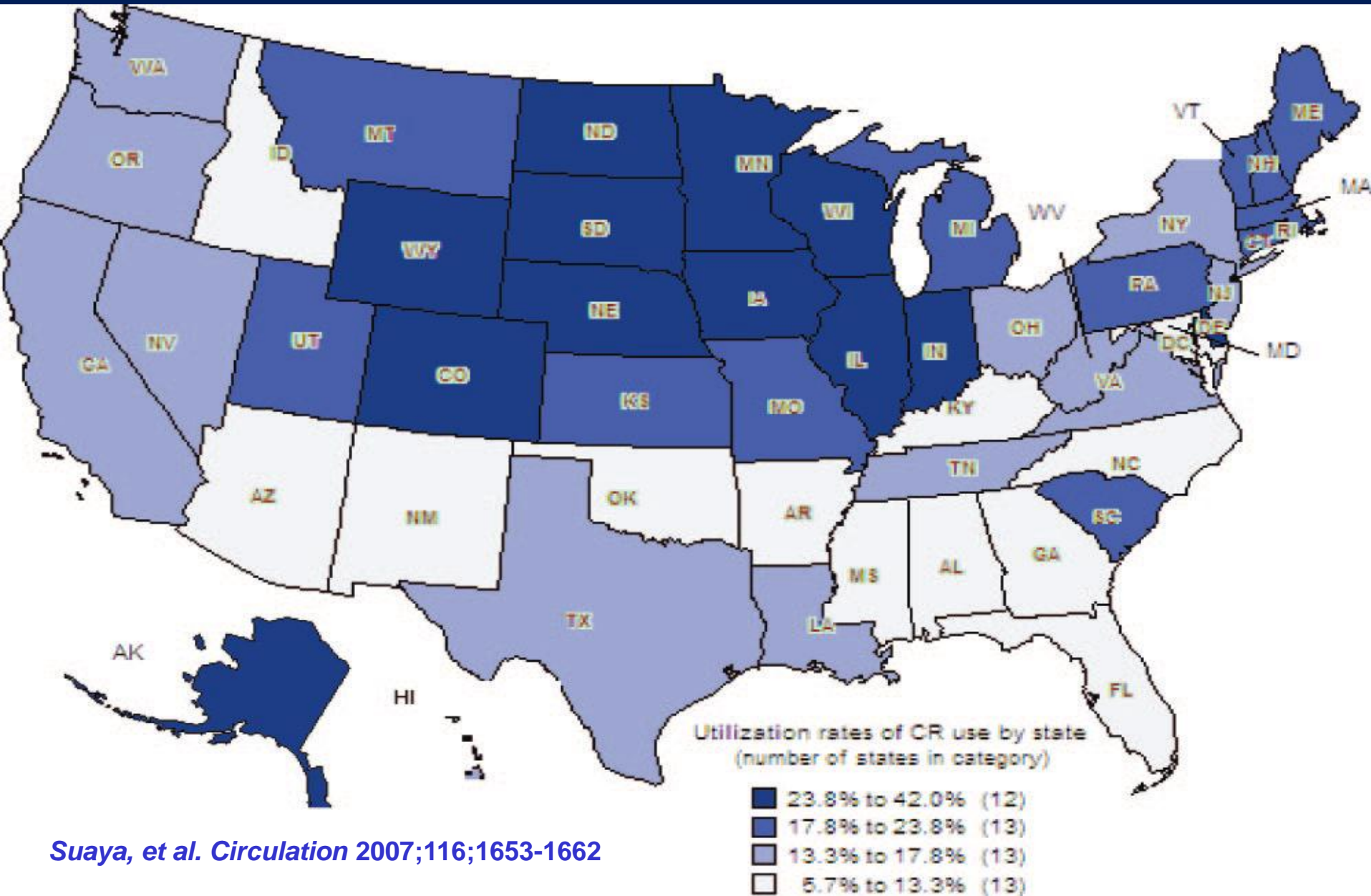
# How are we doing with referrals?

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- *Use of Cardiac Rehabilitation by Medicare Beneficiaries After Myocardial Infarction or Coronary Bypass Surgery*
  - Jose A. Suaya, MD, PhD; Donald S. Shepard, PhD; Sharon-Lise T. Normand, PhD; Philip A. Ades, MD; Jeffrey Prottas, PhD; William B. Stason, MD, MSc
- In their study, the authors report that only 50,000 (18.7%) of 267,427 Medicare-eligible patients 65 years of age who experienced a CHD event (myocardial infarction or coronary artery bypass graft surgery in this case) in 1997 actually participated in a CRSP program.

# Utilization Rates of CR by State:

Indiana is barely in top quartile in 1997 (23.8%)



# Local Center of Excellence Experience

- ~30% of Clarian Cardiovascular Eligible patients participate in Phase II cardiac rehab programs after discharge (half at Methodist and half at outside institutions).
  - Personal communication.

# Barriers to CR Referral/Participation<sup>1</sup>

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- Patient
  - <50% of referred patients complete CR<sup>2</sup>
  - Patients don't hear from their physicians that this is important and recommended for their recovery and care
- Physician
  - Complexity of referral process and time constraints
  - Ignorance of the incremental benefits of CR
- System
  - Lack of strong voice
  - Competition with inpatient resources vs. outpatient/preventive services
- Community
  - Lack of community support and policies
    - Parks, sidewalks, smoking bans and menu-labeling to promote prevention

1. *Circulation* 2007;116;1644-1646

2. *J Cardiopulm Rehabil.* 2004;24:157–164

# At Risk Populations: No Referral

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- Older age
- Female
- Nonwhite racial/ethnic status
- Lower socioeconomic status
- Significant comorbid conditions
- Long distance from the patient's home to a CR center.

# Opportunities to Improve CR Utilization: Breaking Down Barriers of Use

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- Automatic referral order sets
- Increased Cardiac Rehab reimbursement
  - Consider “pay for performance”
- Increase Cardiac Rehab availability
  - If utilization increases, we may rapidly saturate available CR slots
  - In study by Suaya, found about 50k medicare eligible patients used CR. If rates of CR approach the 53% referral seen in Nebraska, that number will increase by >90k patients

# **AACVPR/ACC/AHA 2007 Performance Measures on Cardiac Rehabilitation for Referral to and Delivery of Cardiac Rehabilitation/Secondary Prevention Services**

Endorsed by the American College of Chest Physicians, American College of Sports Medicine, American Physical Therapy Association, Canadian Association of Cardiac Rehabilitation, European Association for Cardiovascular Prevention and Rehabilitation, Inter-American Heart Foundation, National Association of Clinical Nurse Specialists, Preventive Cardiovascular Nurses Association, and the Society of Thoracic Surgeons

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# CR Performance Measures Goals

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- The Writing Committee was given the charge of developing performance measures that cover 2 specific aspects of CR services:
  - 1) referral of eligible patients to a CR program
    - All hospitalized/outpatients with eligible diagnosis are referred for CR program
  - 2) delivery of CR services through multidisciplinary CR programs.
    - Details the structural and process components of CR programs to ensure continued quality of care improvement while optimizing patient outcomes